MARGARET WOOD HASSAN
Governor

STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

October 20, 2014

Congressman Fred Upton, Chair
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Upton:

Thank you for seeking New Hampshire's feedback on the CHIP Medicaid expansion program for children. We strongly support the reauthorization of CHIP until at least 2019 to both allow sufficient time to ensure that health plans have the ability to serve children with special and intensive needs and to allow Congress to make the technical corrections necessary to the Patient Protection and Affordable Care Act to allow families to more easily access Marketplace plans.

In addition, a change in CHIP Medicaid now would unfairly penalize New Hampshire's children and taxpayers for the state's fiscal responsibility. Several years ago, in a change that reduced state and federal costs, New Hampshire moved its CHIP program into Medicaid. Failure to reauthorize would penalize New Hampshire's efficiency by forcing it to pay more for children's health coverage than other states.

Below you will find New Hampshire's specific responses to the questions posed by the Ranking Members of the House Committee on Energy and Commerce and the Senate Finance Committee on the impact the end of Title XXI CHIP funding could mean to low-to moderate income families. We have also included information about the health status of children in our CHIP population, which we think supports recent analyses by a number of organizations that the Qualified Health Plans (QHPs) on the Marketplace may not meet children's needs, especially our must vulnerable children, those with special health care needs.[1]

1. How many individuals are served by your state's CHIP Program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?

As of June 30, 2014, New Hampshire had 11,029 children in its CHIP population; about 44 percent were adolescents (12-18 years old). NH has a CHIP Medicaid Expansion (meaning that the CHIP population is enrolled via the Medicaid program as opposed to a stand-alone program outside of Medicaid) to serve these children in the 185-300 percent FPL income group.

[1] The National Alliance to Advance Adolescent Health, Georgetown University Health Policy Institute Center for Children and Families, Wakely Consulting Group, MACPAC and the GAO.

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.nh.gov/ • Email: governorhassan@nh.gov
TDD Access: Relay NH 1-800-735-2964

Approximately three-quarters of these children are in the 185-250 percent FPL income group. Previous analyses of children's health insurance in New Hampshire showed that about half the CHIP program population dis-enrolls each year compared to about one-quarter each of the Medicaid and commercial populations.

These previous analyses of children's health insurance in New Hampshire also included health status classification using a relative clinical risk score (3M's Clinical Risk Grouping software), which showed that among those continuously enrolled (for a year) Medicaid children had the highest score (0.591) with the CHIP population somewhat lower (0.549) but still 10 percent higher than commercially insured children (0.494). Despite similar demographics to the commercially insured children, this group had a higher prevalence rate of mental health disorders (22.7 percent versus 14.2 percent) and about twice the prevalence rate of asthma. The last study, released in 2013, found a shift toward a greater level of chronic disease in CHIP children.[2]

This trend is of concern and supports the need for access to a health benefit plan that addresses the acute and chronic health care needs of children. Despite this shift towards greater chronic illnesses, there are positive outcomes for New Hampshire's children enrolled in the CHIP program. On average CHIP funding allows New Hampshire to provide health care coverage to more than 19,000 children during the course of a year. Over the course of a year CHIP funding in New Hampshire assures access to 46,000 physician/clinic visits (including 6,500 for preventive care), 20,000 dental visits, 10,000 mental health visits, 2,500 emergency department visits, and 57,000 prescriptions filled.

As a result of this care:

- The access to and use of primary care practitioners has improved such that New Hampshire's CHIP rates were higher than both Medicaid and the New Hampshire Commercial rates in the 2013 study.
- Well-child visit rates have increased substantially with the children enrolled in CHIP leading the way (83.9 percent) followed by the commercial insurance (79.3 percent) and Medicaid (73.2 percent).
- Children enrolled in the CHIP program saw a significant improvement in the rates for the appropriate testing and treatment for ambulatory sensitive conditions (ASC) that could be treated in a physician's office rather than in the emergency room. (SFY2011 (88.7 percent) vs SFY2009 (80.0 percent).
- The use of inpatient hospital services for ASC (asthma, dehydration, bacterial pneumonias, urinary tract infections and gastroenteritis), by children enrolled in the CHIP program (1.6 per 1,000 members) are much less than children enrolled in the Medicaid program (3.4 per 1,000 members) and equal to those with commercial insurance.

Without the CHIP Program, New Hampshire would not have seen such improvements. This is why it is vital that before decisions are made to end the CHIP program, in favor of providing a health benefit through the Marketplace, an analysis of impact on health outcomes

[2] Onpoint Health Data for NH DHHS. *Children's Health Insurance Programs in New Hampshire*. June 2013.

must be undertaken. To not look at this question is inviting a cascade of negative, harmful, unintended outcomes for children.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

New Hampshire has applied the new Modified Adjusted Gross Income or MAGI regulations as required by the PPACA to its CHIP program. The key differences between MAGI and the former method for calculating income is the use of a standard 5 percent income disregard and no asset test.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

New Hampshire is a CHIP Medicaid Expansion state; children in the CHIP population receive the Medicaid benefit package, which is a broader set of benefits important to children and adolescents and can often be significant to those with special health needs. There is no cost sharing in New Hampshire Children's Medicaid. Families would face considerably higher out-of-pockets costs for their children's health care in a Qualified Health Plan (QHP); for lower-income families that might be anywhere from 2.2 to 8.3 times higher than a separate CHIP program[3], more so in a CHIP Medicaid Expansion state like New Hampshire. The impact on children with special health care needs could be devastating – some families could go from paying nothing in CHIP to facing more than $5,000 in annual out-of-pocket costs in QHPs.[4] Some of these current services in New Hampshire have limited or no coverage in Marketplace or commercial plans, e.g., dental, audiology exams and hearing aids, non-emergent transportation and Early Periodic Screening, Diagnosis and Treatment services. Of particular concern to children's well-being is dental care. Families will forego dental care if it means purchasing a stand-alone dental plan with additional premiums and cost sharing that doesn't count toward their medical deductibles and out-of-pocket maximum.

It is too early to tell how the Marketplace plans will serve children in New Hampshire. Several new carriers offering multiple health plans are poised to enter the Marketplace for 2015 after only one carrier participated in 2014. There are no plans in New Hampshire to require any benefits beyond the Essential Health Benefits and Early Periodic Screening, Diagnosis and Treatment (EPSDT) services as required for individuals that are 19 and 20 years of age who are found eligible for the NH Health Protection Program (PPACA Medicaid Expansion).

---

[3] Brooks, T, Heberlein, M., Fu, J. *Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs*. Georgetown University Health Policy Institute Center for Children and Families. May 2014.

[4] Wakely Consulting Group. *Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans*. July 2014.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP would become uninsured in the absence of CHIP?

Yes, CHIP funding should be extended through 2019 when the PPACA Maintenance of Effort (MOE) requirements ends. New Hampshire – as a Medicaid Expansion state – must cover this population through 2019 due to the federal government's MOE requirement. It would be catastrophic if New Hampshire were obligated to continue CHIP without relief from the MOE requirement. While Medicaid funding would not run out, NH's contribution to covering these children would increase significantly. Cost increases would need to be offset by other Medicaid cuts at a time when we are developing a new system of care. New Hampshire is one of the states that would be subject to an inequitable financial impact as states with separate CHIP programs would end those programs when CHIP funding expired.[5]

Congress needs to address this issue as soon as possible. New Hampshire is building its 2016-2017 biennium budget. It will be difficult planning for an uncertain outcome that could involve significant increased costs for covering these children.

During the time period Congress extends CHIP funding, it is imperative that analyses are done regarding the benefit packages, cost sharing and network adequacy of Marketplace plans and their impact on the needs of low-income children. If deemed necessary, Congress should act to revise Marketplace plan requirements for children. In particular, PPACA's affordability test (the "family glitch") that counts *only* the employee's cost of Employer Sponsored Insurance (ESI) has the potential to erase many of the gains made in reducing uninsurance among children, if CHIP funding ends and families cannot afford ESI but are prevented from accessing subsidies in the exchange.[6]

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

New Hampshire has been able to work within its annual allotment due to a July 2012 policy change that moved the children in the separate CHIP program to the CHIP Medicaid Expansion. The cost of the separate program was outstripping legislative appropriations and New Hampshire came dangerously close to capping enrollment and/or instituting a wait list for the

---

[5] MACPAC (Medicaid and CHIP Payment Access Commission). *Report to the Congress on Medicaid and CHIP*. June 2014.

[6] Sara Rosenbaum discusses two basic PPACA "design flaws" in her Milbank Quarterly Op-Ed piece (volume 92, Issue 3, 2014): inadequate cost-sharing help for low income families and the family "affordability" problem that bars families from accessing premium subsidies for their children.

first time in the history of its CHIP program (with CMS approval). Moving to a CHIP Medicaid Expansion allowed NH to stay within its legislative appropriation, continue to cover all eligible children, provide comprehensive benefits, and maintain its low rate of uninsured children.

Depending on what Congress does, it may not be necessary to further address unspent allotments if CHIP funding is temporarily extended while the critical analytical work that is needed is done.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that can help states do an even better job of enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

As indicated in question #4, policy changes should focus on technical issues with the PPACA and their effect on enrollment of children and the resulting impact on the rate of uninsurance among children, which could erase many of the gains this nation has made in children's coverage. If Congress intends to end CHIP funding, it should put in place a temporary extension and focus its policy attention on the affordability, accessibility and appropriateness of Marketplace plans for children during an extension period.

In summary, the CHIP funding extension to 2019 will allow time for Congress to fix the existing Marketplace technical issues that left unattended, and in combination with not reauthorizing CHIP funding, will prove to be catastrophic for New Hampshire families. In addition the extension will allow time for the critical analytical work to be done that is required to support informed decision-making by Congress about the future of the CHIP funding. That analytic work includes, but is not limited to:

- Assessing the impact of the existing "family glitch", which could keep half of the children on CHIP from accessing Marketplace Plans;
- Ensuring that QHPs are designed to meet children's health care needs with attention to children with special health care needs;
- Examining cost sharing in order to arrive at a family contribution that is fair and encourages QHP enrollment and appropriate use of health care services;
- Assessing whether stand-alone dental plans and their additional cost sharing are appropriate; and
- Designing tools to help families choose the best coverage in the Marketplace for their children.

Thank you for this opportunity to offer New Hampshire's perspective. We recommend and request that Congress extends funding for CHIP through 2019 and uses the time to perform the careful analyses MACPAC and others are calling for to make certain that the cost-sharing and benefits in Marketplace plans are affordable and appropriate for children. It is would be

premature to eliminate support for this program without understanding the impact of such action without adequate time for states to do the necessary planning and budget adjustments.

With every good wish,

[redacted]

Margaret Wood Hassan
Governor

cc: Congressman Henry Waxman
Senator Ron Wyden
Senator Orrin Hatch
Senator Jeanne Shaheen
Senator Kelly Ayotte
Congresswoman Carol Shea-Porter
Congresswoman Ann Kuster
Katie Dunn, Associate Commissioner and Medicaid Director, NH DHHS

107 North Main Street, State House - Rm 208, Concord, New Hampshire 03301
Telephone (603) 271-2121 • FAX (603) 271-7640
Website: http://www.nh.gov/ • Email: governorhassan@nh.gov
TDD Access: Relay NH 1-800-735-2964

HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Sidonie Squier, Secretary
Julie B. Weinberg, Director

October 30, 2014

The Honorable Ron Wyden
Chairman
Senate Finance Committee

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee

The Honorable Henry Waxman
Ranking Member
House Energy & Commerce Committee

Dear Congressmen:

Thank you for your July letter to governors seeking information and feedback about the Children's Health Insurance Program (CHIP), including policy recommendations for the program as Congress considers the future of CHIP and the reauthorization of funding beyond federal fiscal year 2015. As you rightly note, both Medicaid and CHIP are operated as state-federal partnerships, and New Mexico appreciates the chance to offer input about imminent policy and financial considerations. In response, we are pleased to answer your questions in greater detail.

CHIP Enrollment Status and Demographics

New Mexico administers CHIP as an expansion of Medicaid, rather than as a stand-alone program. While CHIP enrollees have some additional cost-sharing responsibilities that differ from traditional Medicaid (discussed in greater detail below), the program itself has the same benefit package, application process and administrative structure as children's Medicaid; and essentially operates as two separate categories to cover children ages 0-5 and 6-18 who do not meet the income maximums for Medicaid.

As of October 1, 2014, New Mexico covered just over 14,000 children under CHIP – a number that has grown significantly since last January, when New Mexico had approximately 7,500 CHIP enrollees. For children 0-5 years-old, income eligibility for CHIP is between 240-300 percent of the federal poverty level (FPL); and for children ages 6-18, income eligibility is between 190-240 percent FPL. Children in families with income below these thresholds are eligible for Medicaid.

Approximately 12 percent of CHIP enrollees are Native American, and about 55 percent reside in rural New Mexico counties. CHIP enrollees are generally considered a healthy population. In New Mexico, most children who are enrolled in CHIP receive services through a managed care organization (MCO), with the exception of Native Americans, who may opt-into or out of managed care.

ACA-Related Changes

The most noteworthy change that New Mexico made to its CHIP program as a result of the Patient Protection and Affordable Care Act (ACA) was the conversion of existing CHIP income thresholds to equivalent income limits based on the modified adjusted gross income (MAGI) methodology. Per Section 2101(f) of the ACA, New Mexico also created a specific sub-category of CHIP for children who lose Medicaid coverage at renewal due to the elimination of income disregards as a result of MAGI conversion. And, like most other Medicaid categories, CHIP is subject to the same streamlined application and renewal processes that are required by the ACA.

CHIP Benefits & Cost-Sharing

Since CHIP operates as an extension of Medicaid in New Mexico, the benefits that are available to CHIP enrollees include the full gamut of physical, behavioral, oral health, vision and Early and Periodic Screening, Diagnosis and Testing (EPSDT) services that are provided to the traditional Medicaid population. There are some notable benefit differences between CHIP and the health plans that are available via most New Mexico employers and the Health Insurance Marketplace, since these plans generally do not include dental services, eyeglasses, vision refraction and psychiatric residential treatment centers comparable to CHIP. The CHIP dental benefit package is the benefit source for stand-alone dental plan offerings available to children on the Marketplace.

New Mexico charges co-payments to CHIP recipients, as outlined below:

Co-Pay	Item or Service
$2	Prescription drug item (Not applied when the co-payment for a brand-name drug is applied.)
$3	Brand-name drug (Applied when there is a less expensive drug available.)
$5	Outpatient visit to a physician or other practitioner, dental visit, therapy session or behavioral health session
$8	Non-emergent use of the emergency room
$25	Inpatient hospital admission

These co-payments are far lower than the cost-sharing provisions of most other commercial and Marketplace health plans. New Mexico CHIP does not charge premiums or deductibles.

Future CHIP Funding

New Mexico receives a higher federal match rate for CHIP enrollees than it does for Title XIX Medicaid recipients, and this additional federal funding has allowed our state to provide health insurance to children whose families have too much income to qualify for Medicaid, but who may have historically struggled to afford the deductibles and premiums associated with private or employer-sponsored coverage. With the creation of the Health Insurance Marketplace and federally subsidized coverage options and cost-sharing reductions, private insurance is now more affordable than when CHIP began years ago. It is interesting to note that CHIP enrollment has increased

substantially in New Mexico since last January, the reasons for which are unclear. While a portion of this enrollment increase may be a "woodwork" effect due to the ACA's individual mandate and the related outreach and visibility of new coverage options, the increase may also reflect that middle-income families might be forgoing private coverage to take advantage of the greater affordability offered by CHIP.

CHIP reauthorization presents an opportunity for Congress to inventory and streamline the wide array of coverage and affordability options that are now available to moderate- and middle-income families. While New Mexico currently uses the federal Marketplace platform, our state is moving quickly toward implementation of a state-based Marketplace for the 2016 open enrollment period. Our experience to date has been that transitioning populations and coordinating coverage between Medicaid and the federally facilitated Marketplace is a clunky and challenging process; and fewer families than originally anticipated have been able or willing to purchase coverage through the Marketplace. Until New Mexico has a mature state-based Marketplace that can ensure a streamlined and seamless process for families in accessing coverage, our state believes that CHIP – and the federal funding that goes with it – will remain an important coverage option for New Mexico families.

No discussion about CHIP funding can be held without recognizing that all states are currently operating under the ACA's maintenance of effort (MOE) provision, which requires the continuation of pre-ACA Medicaid and CHIP coverage levels for children through 2019. Federal rules for maintaining eligibility are unclear should CHIP allotments be discontinued, and any Congressional action on CHIP funding must make clear that the MOE provision would not apply should federal funding for the program be reduced or disappear altogether.

CHIP Allotments

The CHIP allotment process and methodology have worked well for New Mexico, and we don't have any specific recommendations for change. Should you consider a new allotment process or methodology, we urge you to keep financial stability and predictability for states at the forefront of your deliberations. We are committed to slowing the growth rate of health care costs while improving the quality of care, especially in Medicaid and CHIP. Large swings in federal financial participation can inhibit those efforts. Given that New Mexico, like most other states, would exhaust federal CHIP allotments during fiscal year 2016 without funding reauthorization, we may need more flexibility and time to adjust to this funding change.

Reaching Uninsured Children

New Mexico agrees that Medicaid and CHIP have been at the frontlines of making headway in reaching uninsured children, and this has historically been where our state has focused much of its attention. In addition to New Mexico's comparatively high Medicaid and CHIP income thresholds, the state has worked hard to facilitate the easiest and most straightforward enrollment and eligibility processes possible – including widespread use of presumptive eligibility for children and pregnant women, implementation of continuous eligibility for child categories, use of administrative renewals, and automatic deeming of newborns as Medicaid- or CHIP-eligible when born to a Medicaid-enrolled mother. These policies have greatly aided our state in not only enrolling uninsured children into coverage, but in facilitating greater retention and ongoing child health improvements. Our state encourages Congress to be innovative and flexible in thinking about how states might continue to develop similar strategies as it works through the CHIP reauthorization process.

In conclusion, let me thank you again for seeking consultation from the states on this important issue. If you have any questions or need additional information, please don't hesitate to let me know.

Sincerely,

[redacted]

Julie B. Weinberg, Director
Medical Assistance Division

STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

ANDREW M. CUOMO
GOVERNOR

September 4, 2014

VIA ELECTRONIC TRANSMISSION

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
United States House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
104 Hart Office Building
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
United States House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Wyden and Upton, and Ranking Members Hatch and Waxman:

Thank you for your recent letter requesting information regarding the Children's Health Insurance Program (CHIP). New York State's CHIP program, Child Health Plus, has been in existence since 1990 and successfully provides comprehensive, affordable insurance coverage to uninsured children throughout the state.

The CHIP program has made an enormous difference in expanding health insurance coverage in New York. When CHIP was enacted, New York had over 800,000 uninsured children. Today, there are about 100,000 uninsured children, nearly a 90 percent decline. We appreciate your interest in collecting information to determine if funding should be continued beyond Federal Fiscal Year 2015. Below are responses to the information requested in your July 29, 2014 letter:

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?**

New York's Child Health Plus program currently is a combination program, meaning children ages 6 to 18 between 100% and 133% of the Federal Poverty Level (FPL) are funded under Title XXI of the Social Security Act through a Medicaid expansion. The separate portion of the program provides subsidized coverage to children from birth through age 18 that are not eligible for Medicaid and in families with incomes under 400% of the FPL ($95,000 for a family of four). Children in families over 400% of the FPL that are otherwise eligible for coverage may enroll in the program at full cost.

As of July 2014, approximately 476,000 children are covered by CHIP: 297,180 in the separate CHIP program and approximately 179,000 through the Medicaid expansion. Attached is additional information describing the demographic characteristics of children enrolled through the separate program, including enrollment by poverty level, immigration status and ethnicity.

2. **What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act (PPACA)? How has the implementation of PPACA impacted the way your state administers CHIP?**

   The biggest change in the administration of the CHIP program as a result of the PPACA is that eligibility determinations are now being performed by the New York State of Health (NYSOH), New York State's health insurance marketplace. NYSOH is an integrated eligibility system for all programs available under the Affordable Care Act, Medicaid, Child Health Plus, and qualified health plans with and without tax credit and cost sharing reductions. Previously, eligibility determinations for Child Health Plus were performed by participating health plans and Medicaid eligibility determinations by local departments of social services.

   Another significant change under the ACA is the use of Modified Adjusted Gross Income (MAGI). Previously, the Child Health Plus program used gross income in determining eligibility. Moving to MAGI resulted in changes such as no longer counting child support or worker's compensation coverage as income. In addition, household composition rules were changed under ACA. The household composition is now based on the tax filing household.

   Other changes have been made as a result of the ACA to more closely align the separate CHIP program with Medicaid eligibility rules.

3. **To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.**

The Child Health Plus program offers subsidized health insurance coverage to children under 400% of the FPL. There are no co-payments or deductibles in the program. Depending on household income, families may be responsible for a monthly premium contribution. Family contribution levels are as follows:

<160% of the FPL	Free
160 to 222% FPL	$9 per child per month/$27 per month family maximum
223 to 250% FPL	$15 per child per month/$45 per month family maximum
251 to 300% FPL	$30 per child per month/$90 per month family maximum
301 to 350% FPL	$45 per child per month/$135 per month family maximum
351 to 400%FPL	$60 per child per month/$180 per month family maximum
Over 400% FPL	Full premium which varies by participating health plan

Child-only policies are available through the NYSOH at a considerably higher cost than Child Health Plus. The child-only policies available within NYSOH have a monthly premium that ranges from $175 to $287 per month as well as cost sharing provisions that range from $15 to $1,500 per service depending on the coverage level. Deductibles for these policies range from $0 to $3,000 depending on income. As noted above, there are no copayments or deductibles in Child Health Plus, and for families with incomes below 400%, FPL the maximum premium contribution is $180 per month depending on income. In New York State, 62% of all enrollees in Child Health Plus pay less than $9 per month.

4. **Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state will be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?**

New York State strongly recommends that CHIP funding be extended. We believe funding through 2019 is the appropriate length of time for an extension. A more informed decision regarding the continuation of the program can be made after NYSOH has had several years of experience.

If the decision is made to not reauthorize CHIP funding, New York believes that states need at least twelve months of lead time in order to plan for, notify, and efficiently transition children to other programs. If the decision is not made with enough lead time, there is the potential that many children covered in the program will become uninsured. Even with sufficient lead time, we anticipate that many children may become uninsured if CHIP were discontinued given the large cost differential between Child Health Plus and the child-only policies on NYSOH.

5. **In spite of restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?**

   To date, New York State has received sufficient funding to support its Child Health Plus program through annual allotments and expansion allotment adjustments. With the potential for program growth under the ACA, New York anticipates there may be a need for increased allotments in the future.

6. **Over the past number of years, States have worked to reduce the number of uninsured children and Medicaid and CHIP have been a critical component in that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any would help improve enrollment of eligible children, reduce the number of uninsured and improve health outcomes for children in your state?**

   New York believes that performance bonuses available under the Children's Health Insurance Program Reauthorization Act (CHIPRA) were an effective means of increasing enrollment under the programs. We suggest that the provision to reinstate performance bonuses be reauthorized.

Thank you again for your consideration in reauthorizing CHIP funding. Should you have any further questions, please feel free to contact Judith Arnold, New York State's CHIP director and the director of the Division of Eligibility and Marketplace Integration via phone at [redacted]

Sincerely,

[redacted]

Courtney Burke
Deputy Secretary for Health

Attachment

Cc: Jason Helgerson, New York State Medicaid Director
Judith Arnold, CHIP Director, New York State

NYS CHILD HEALTH PLUS PROGRAM

Household Income - Federal Poverty Level	Enrollment*	% of Total
<160% FPL	74,165	25%
160-222% FPL	109,451	37%
223-250% FPL	35,664	12%
251-300% FPL	36,582	12%
301-350% FPL	20,709	7%
351-400% FPL	11,598	4%
> 400% FPL	9,011	3%
Grand Total	297,180	100%
Total Subsidized	288,169	97%
CITIZENSHIP		
Citizen	256,757	86%
Qualified Immigrant	8,335	3%
Unqualified Immigrant	32,088	11%
Total	297,180	100%
RESIDENCE		
NYC	104,276	35%
Rest of State	192,904	65%
Total	297,180	100%
ETHNICITY		
Asian	23,157	8%
Black	19,340	7%
Hispanic	46,830	16%
American Indian	311	0%
Pacific Islander/Hawaiian N	230	0%
Unknown	85,668	29%
White	121,644	41%
Total	297,180	100%

* July 2014 Enrollment

North Carolina Department of Health and Human Services
Division of Medical Assistance

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Robin Gary Cummings, M.D.
Deputy Secretary for Health Services
Director, Division of Medical Assistance

November 10, 2014

The Honorable Ron Wyden
Chairman
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
House Energy & Commerce Committee
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Wyden, Ranking Member Hatch, Chairman Upton and Ranking Member Waxman:

On behalf of Governor Pat McCrory, I am responding to your recent letter asking for North Carolina's input on the Children's Health Insurance Program (CHIP). We have provided detailed responses and data that may assist in your discussions on CHIP reauthorization.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

North Carolina has four groups of children funded under Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP):

PROGRAM	AGE RANGE	FAMILY INCOME ELIGIBILITY
Medicaid expansion	Birth – 12 months	186 – 200% FPL
Medicaid expansion	13 months – 5 years	134 – 200% FPL
Medicaid expansion	6 – 18 years	101 – 133% FPL
Separate CHIP Program	6 – 18 years	134 – 200% FPL

Note: Federal Poverty Limit (FPL)

Under the Medicaid expansion programs, children receive the full range of Medicaid services paid for using Title XXI (CHIP) funds. These children are considered enrolled in Medicaid. Title XXI funding, with its enhanced Federal matching rate, allows North Carolina to provide these children with a richer array of services necessary early in life at a reduced cost to the State.

NC Health Choice program beneficiary enrollment in July 2014 exceeded 82,000. NC Health Choice beneficiaries reside in all 100 counties, but the number of beneficiaries varies from only 57 in one coastal county to more than 5,700 in one southwestern county. The average number of NC Health Choice beneficiaries per county is 821. See the figures below for the beneficiary age distribution, gender distribution, and income distribution.

Figure 1: NC Health Choice Beneficiaries by Age: July 2014

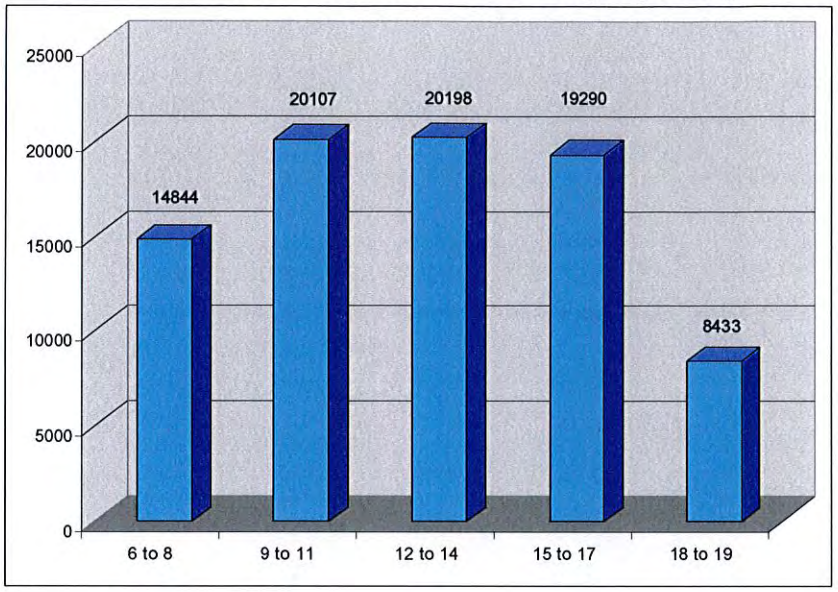


Figure 2: NC Health Choice Beneficiaries by Gender: July 2014

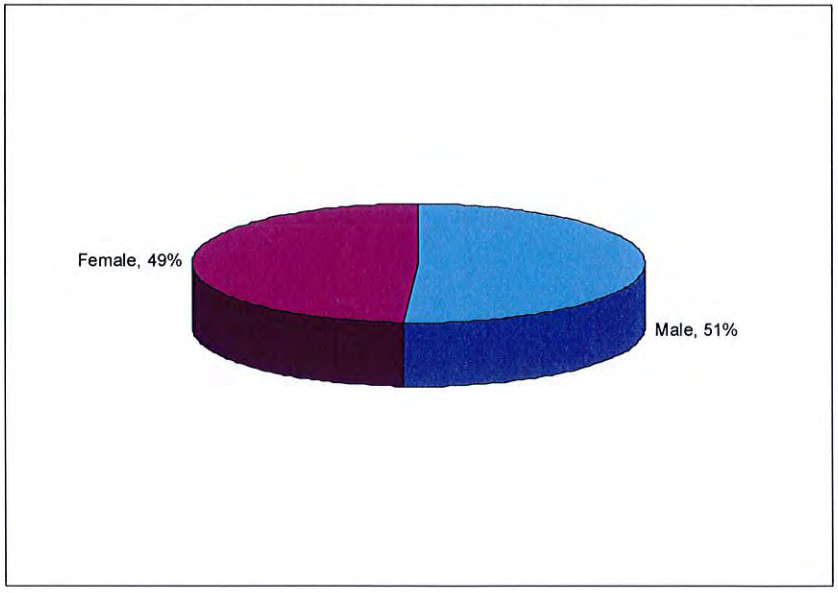
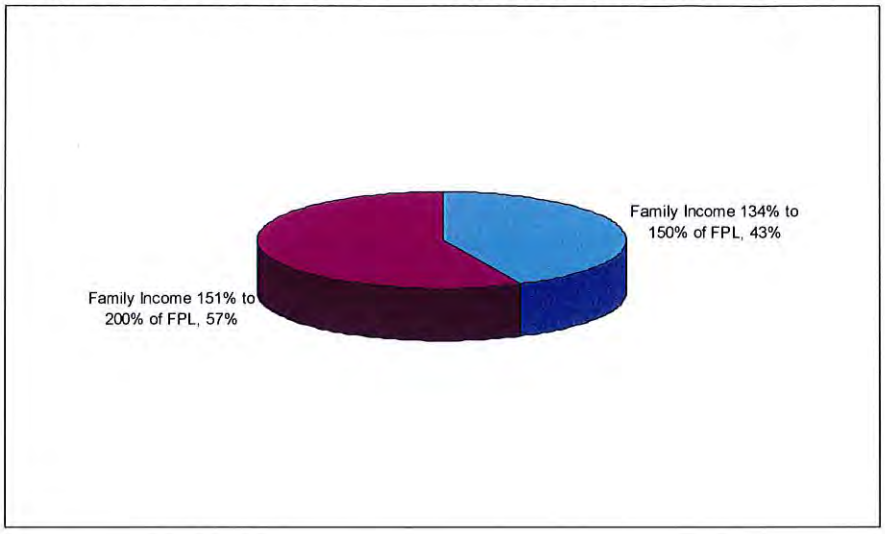


Figure 3: NC Health Choice Beneficiaries by Income: July 2014



2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

As a part of Affordable Care Act implementation, North Carolina modified its Health Choice Program eligibility to reflect the new Modified Adjusted Gross Income (MAGI) requirements that expand Medicaid for children to 133 percent FPL. As a result, approximately 72,000 children aged 6 through 18 who were previously eligible for NC Health Choice became eligible for Medicaid coverage on January 1, 2014.

Other than the new MAGI eligibility formula for both Medicaid and CHIP program applicants and the aforementioned shift in the income eligibility threshold, the Affordable Care Act has not affected the way that North Carolina administers the separate CHIP program. North Carolina uses one joint application for Medicaid and CHIP. Local county departments of social services workers screen applicants for Medicaid first. If household income exceeds Medicaid limits, workers then screen applicants for CHIP.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Benefits coverage for the North Carolina CHIP program is controlled by federal Title XXI statutes, NC General Statutes, and the Centers for Medicare and Medicaid Services (CMS)-approved State Plan. NC Health Choice program services covered include many but not all of those allowable under federal Title XXI law:

- Inpatient hospital services;
- Outpatient hospital services;
- Physician services;
- surgical services;
- Clinic services, including ambulatory health centers and local health departments;
- Pharmacy benefits;
- Laboratory services;
- Radiological services;
- Mental health services;
- Durable medical equipment and medical supplies;
- Nursing services;
- Substance abuse treatment;
- Case management;
- Care coordination;
- Specialized therapies;
- Hospice care;
- Emergency medical transportation; and
- Preventive and restorative dental services.

Detailed Division of Medical Assistance Clinical Coverage policies for NC Health Choice program benefits are located at http://www.ncdhhs.gov/dma/mp/index.htm.

North Carolina General Statutes mandate that the separate CHIP program benefits be equivalent to Medicaid benefits. There are a few exceptions, as outlined in N.C.G.S. 108A-70.21(b):

(1) No services for long-term care;
(2) No non-emergency medical transportation;
(3) No federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements; and
(4) Restricted dental services.

Cost sharing for the NC Health Choice Program is also outlined in the General Statutes and the CMS-approved State Plan. N.C.G.S. 108A-70.21(d) and (e) outline that there is no cost-sharing for families with incomes below 150 percent FPL, except for a $1 copay on generic prescription drugs and a $3 copay on brand name prescription drugs.

Families with incomes above 150 percent FPL are subject to greater cost-sharing, including a $5 copay for provider visits and outpatient hospital visits, excluding well-baby, well-child, or immunization visits. There is also a $1 copay for generic prescriptions, a $10 copay for brand

name prescriptions, and a $20 copay for non-emergency emergency department visits. Overall cost-sharing per family cannot exceed 5 percent of the family's annual income.

The table on the following page shows a comparison of NC Health Choice cost sharing with the North Carolina's Teachers and State Employees Health Plan (SHP) benefit plan and a Silver Blue Cross Blue Shield (BCBS) plan on the Federally Facilitated Marketplace (FFM). Both NC Health Choice and the FFM BCBS plan include medical and dental coverage; the SHP includes only medical coverage. The SHP insures nearly 700,000 State employees.

Income for a family of four living at 200 percent of the 2014 FPL is $47,700. This family income qualifies for NC Health Choice. Higher family income qualifies for both a health insurance premium tax credit and cost sharing reductions on the FFM. There are three broad qualifying criteria for the premium tax credit (See: http://www.irs.gov/uac/Newsroom/The-Premium-Tax-Credit2):

1) the individual must purchase health insurance coverage through the FFM;

2) household income cannot exceed 400 percent of the FPL; and

3) the individual cannot be eligible for other coverage such as Medicare, Medicaid, or employer-sponsored coverage.

Cost sharing reductions are limited to Silver plans in the Bronze, Silver, Gold, Platinum continuum on the FFM. The SHP example in the table represents a 70 percent coverage/30 percent coinsurance plan option for comparison purposes because Silver plans have 70/30 coverage.

Comparison of NC CHIP, Employer-Sponsored, and FFM Health Insurance Cost Sharing

	NC Health Choice	**NC Teachers and State Employees 70/30 Health Plan with BCBS (SHP)[2]**	**NC Federally Facilitated Marketplace 70/30 Silver Plan with BCBS[3]**
Monthly Premium	(individual) $0 (family) $0 Annual enrollment fee of $50 per child or $100 per family for applicants living at 151% -200% of FPL	(individual employee) $0 for employee; paid by the State (employee + 1 or more children) $205.12 (employee + spouse + 1 or more children) $562.94	(individual child) $139**
Annual Deductible	(individual) $0 (family) $0	(individual) $933 (family) $2,799	(individual child) $5,000 (Pharmacy) $200
Coinsurance	(individual) $0 (family) $0	(individual) 30% of eligible expenses *after* deductible (family) 30% of eligible expenses *after* deductible	
Coinsurance Maximum (*excludes* deductible)	(individual) 5% of household income, or $2,385* (family) 5% of household income, or $2,385*	(individual) $3,793 (family) $11,379 (pharmacy) $2,500	(individual child) $6,350** (pharmacy) $0
Preventive / Wellness Visit co-payment	$0 for all beneficiaries	$35 primary care $81 specialist	$25 primary care
Other Provider Office Visit Co-payment	$0 for beneficiaries living at 134% -150% of FPL $5 for beneficiaries living at 151% -200% of FPL	$35 primary care or mental health $81 specialist	$25 primary care $50 specialist
Inpatient Hospital Co-payment	$0 for all beneficiaries	$291 co-pay, then 30% *after* deductible for hospital services 30% after deductible for provider services in the hospital	30% *after* deductible
Prescription Drug Co-payment	• $1 generic for all beneficiaries • $3 brand if generic available for beneficiaries living at 134% -150% of FPL • $10 brand if generic available for beneficiaries living at 151% -200% of FPL	Range of $12 - $125 tiered co-pays depending on tier *and* brand if generic available	*After* deductible: • $10 generic • $50 preferred • $70 non-preferred

** For a family of 4 living at 200% of the 2014 federal poverty level ($47,700).*
***Before any applicable premium tax credits or cost sharing reductions.*
See: http://www.shpnc.org/library/pdf/annual-enrollment/2015/med-prime-comp-chart.pdf , *State Health Plan 70/30 plan* and https://www.healthcare.gov/find-premium-estimates/#results/&aud=indv&type=med&state=NC&county=Durham&age0=10&employerCoverage=no&householdSize=4&income, Blue Value Silver 5000.

In North Carolina's FFM, a BCBS's 70/30 Silver plan monthly premiums for a 10 year-old child is $139/month, with an individual maximum deductible of $5,000/year and an individual maximum coinsurance of $6,350/year, adding up to approximately $13,000/year in annual out-of-pocket expenses for only one child before any premium tax credits or cost sharing reductions. For NC Health Choice, maximum out-of-pocket expense would be only 5 percent of household income or $2,385 for a household with one *or more* children.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absences of CHIP?

According to the NC Institute of Medicine's (NCIOM) 2013 *Child Health Report Card*, "More than 160,000 children in NC slipped into poverty during the recent recession, as the percentage of poor children increased from 19.5 percent of the child population in 2007 to 26 percent - more than one in every four children - in 2012." However, the NCIOM reported that in a five year period from 2007 to 2012, the percentage of uninsured children living under 200 percent of the FPL in North Carolina *decreased* from 20.6 percent to 11.4 percent. The report also states that the number of children covered by public health insurance (Medicaid or NC Health Choice) rose from 896,792 in 2007 to 1,135,016 in 2012. 4. (See: NC Institute of Medicine, *2013 Child Health Report Card*, http://www.nciom.org/wp-content/uploads/2013/12/2013_CHRC-121913hi.pdf).

North Carolina supports extended funding of the CHIP program beyond federal fiscal year 2015. In North Carolina alone, based on the July 2014 enrollment statistics, 80,000 children would become uninsured in the absence of CHIP. And as long as household income remains at or above 134 percent of the federal poverty level, those children would not qualify for Medicaid. They would therefore only be eligible for employer-sponsored or private health insurance coverage in a plan available on the Federally Facilitated Marketplace.

If CHIP program funding is not extended, there will be fewer insurance options for children living in low-income families in North Carolina. Although comparable benefits may be available in the FFM, low income families' out-of-pocket expenses may be higher than they are for low income families with children enrolled in the North Carolina CHIP Program. The side-by-side comparison in the table shows that cost sharing could be a prohibitively expensive factor for families even if their children qualify for insurance on the FFM, depending in part on the amount of applicable premium tax credits or cost sharing reductions.

Federal legislators and administrators at the Centers for Medicare and Medicaid Services already know that program beneficiaries "churn" back and forth within the CHIP and Medicaid programs as a result of low income families' sometimes transient or even seasonal work and fluctuating income statuses. When family income temporarily becomes too high for CHIP program eligibility but too low to allow a family to afford a private insurance policy on the FFM, the children in those families will be at risk for being uninsured, gaps in coverage, and limited to no access to preventive screenings, treatment, prescription medications, or behavioral health interventions for chronic conditions. Cost-effectiveness studies have shown that preventive care saves millions of dollars in long-term treatment for preventable chronic conditions and co-morbidities. CHIP program funding is therefore an investment in the health and future of North Carolina's and America's low income children.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

Federal allotments received for the North Carolina CHIP program have been sufficient to fund operations within the framework of the existing State budget for the program. North Carolina recommends that any modifications to the formula addressing unspent allotments should account for the shift of previously eligible children from CHIP programs to State Medicaid programs as a result of the Affordable Care Act MAGI eligibility threshold changes.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

North Carolina's outreach and enrollment processes have been very effective. North Carolina has qualified for Children's Health Insurance Program Reauthorization Act (CHIPRA) Performance Bonus awards for enrollment and retention for the past three consecutive years. Given the enhanced outreach inherent to FFM implementation and successful State outreach and

enrollment in recent years, North Carolina does not have any policy recommendations or requests for improvements for federal program enrollment regulations.

However, North Carolina encourages increased flexibility in the design and implementation of our health care delivery systems and federal funding streams so that we may address the unique needs of North Carolinians.

Thank you again for your letter. Please feel free to contact me or my staff if you need any additional information.

Sincerely,

[redacted]
Robin Cummings, MD
Director

cc: Governor Pat McCrory, State of North Carolina
Secretary Aldona Wos, MD, North Carolina Department of Health & Human Services

north dakota department of human services

Fiscal Administration

(701) 328-1980
Fax (701) 328-1030
Toll Free 1-800-472-2622
ND Relay TTY 1-800-366-6888

Jack Dalrymple, Governor
Maggie D. Anderson, Executive Director

October 28, 2014

Representative Fred Upton
Chairman
House Committee on Energy and Commerce

Representative Henry A. Waxman
Ranking Member
House Committee on Energy and Commerce

Senator Ron Wyden
Chairman
Senate Finance Committee

Senator Orrin G. Hatch
Ranking Member
Senate Finance Committee

Re: State of North Dakota's Insight on CHIP

Dear Congressmen:

Governor Dalrymple has asked me to respond to your request for responses to questions you posed in your July 29, 2014, letter about the Children's Health Insurance Program (CHIP). Following are the North Dakota responses to your questions.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

   As of July 1, 2014, approximately 3,200 children are served by North Dakota's CHIP. The income level is set at 175% of the Federal Poverty Level using Modified Adjusted Gross Income (MAGI). Children are enrolled through age 18.

   Out of the 3,200 children enrolled, there are 430 American Indian children enrolled.

For the 12 months of calendar year 2013, there were 1,507 children that had coverage for the 12 calendar months. Of those 1,507:

- 79% (1,180) of children enrolled in Healthy Steps have been seen by a primary care provider.
- 71% (87) age 13 (122 children age 13 had continuous coverage) have received meningitis and T-Dap vaccines.
- There were 139 children with Asthma.
- There were 20 children with Type 1 diabetes.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

As required in the Affordable Care Act, on January 1, 2014, eligibility determination for Medicaid and the Children's Health Insurance Program changed to use Modified Adjusted Gross Income (MAGI). This new eligibility determination process does not allow the use of income disregards. Children previously enrolled in Medicaid who are no longer eligible for Medicaid due to the elimination of income disregards are eligible for coverage through CHIP for 12 months. This 12-month CHIP eligibility period is intended as a way to ensure a smooth transition and continuity of coverage for children as the new income eligibility rules in the Affordable Care Act take effect. After the 12-month coverage period, the family will be able to apply again for health care coverage and if the family no longer qualifies for Medicaid or CHIP, they will be directed to apply for coverage inside or outside the Federal Marketplace.

The Department began transitioning children in April 2014, and the transition will be ending in December 2014. In accordance with the ACA mandates, North Dakota no longer allows a three-year average for self-employed individuals for income determination. This appears to be having an impact on families who report farm income.

Prior to the ACA, North Dakota policy included a six month waiting period for dropped coverage (crowd out period). In accordance with the requirements in the ACA, the waiting period has been reduced to 90 days.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

This information is not available.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

   The North Dakota CHIP has been successful and has been supported by policy makers and many advocacy organizations. The Executive Budget request for the 2015–2017 biennium assumes continued federal CHIP funding. The North Dakota legislative session will be January through April 2015, so a funding decision as soon as possible would be appreciated. The Department of Human Services' does not have information available to estimate the coverage options that would be available for children should CHIP funding cease. We could expect that some children may be able to join the coverage policy from a parent or access coverage through a child-only policy. However, we do not collect or maintain information that allows us to estimate the percent of children that would retain some type of low-cost or free coverage or the percent of children that may become uninsured.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately?

   Yes, the funding formula has been sufficient for North Dakota. Currently we are carrying over and spending the remaining previous federal fiscal year allotment within the second quarter of the subsequent federal fiscal year.

   Do you believe there is a need for Congress to further address the issue of unspent allotments?

   North Dakota has not had significant, multiple-year unspent allotments and we do not have perspective to provide a recommendation on this.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children?

   The alignment of federal policies could strengthen enrollment efforts. For example, guidelines for determining family/household based income being consistent across similar economic assistance programs such as:

SNAP = Supplemental Nutrition Assistance Program
TANF = Temporary Assistance for Needy Families
CCA = Child Care Assistance Program

What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

North Dakota does not have additional policy change suggestions.

Thank you for your work to look at funding for the Children's Health Insurance Program. Should you have any additional questions, please contact me at [redacted] or Governor Dalrymple's Health and Human Services policy advisor, Tami Ternes, [redacted]

Sincerely,

[redacted]

Maggie D. Anderson
Executive Director

Ohio | Department of Medicaid

John R. Kasich, Governor
John B. McCarthy, Director

November 6, 2014

Chairman Fred Upton
House Committee on Energy and Commerce
2183 Rayburn House Office Building
Washington, D.C. 20515

Chairman Upton,

On behalf of Governor John Kasich, I would like to thank you for the opportunity to weigh in on the debate over funding for the Children's Health Insurance Program (CHIP). Ohio remains committed to improving the health and well-being of its children and looks forward to working with the Federal government to improve their future.

Ohio's CHIP program is administered as an extension of the Ohio Medicaid program covering children who come from households with income under 200% of the Federal Poverty Level. Children enrolled in CHIP have access to all Medicaid benefits including vision, dental, behavioral health services, physical health, and most importantly early periodic, screening, diagnosis and treatment (EPSDT) services. Additionally, there is no cost sharing for services. With the way Ohio has chosen to administer CHIP, there was no need for changes due to the Patient Protection and Affordable Care Act (PPACA). Ohio currently covers 151,605 children under CHIP with 51% of them being male and 49% female. Roughly 74% of the population is Caucasian, 23% African American, 2% Asian/Pacific Islander, and 1% listed other.

To continue our successes in connecting children to coverage, Ohio and other states need clarity on what Congress plans to do sooner rather than later. A decision regarding tens of millions of dollars requires ample time for states to properly budget. Should the Federal government choose not to fund CHIP, Ohio must continue to cover the children and the services they receive unless there is a corresponding change in the Federal Maintenance of Effort (MOE) requirement under the Affordable Care Act. That would mean a reduction in the federal matching percentage for those services from 73.85% to 62.64%, which equates to an 11.21% cut in funding to the state. The difference would have to be covered by state dollars which would cause a significant budget deficit. The timeline for Ohio's budget process sees a budget bill being introduced in early February with passage occurring prior to the start of a new state fiscal year on July 1, 2015. This needs to be taken into consideration when Congress makes their decision moving forward. Ohio's CHIP allotment has worked well for the state and has sufficiently covered all of its CHIP expenditures, therefore Ohio does not recommend any

changes in that area.

Ohio's children remain a priority and through Medicaid, CHIP, and private insurance, Ohio has covered roughly 95% of its children. Ohio has received over $63 million since 2010 in Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) bonuses. CHIPRA dollars have gone on to fund and supplement funding for modernization of the Medicaid program and for innovative strategies in providing services. Ohio has also made a major step towards simplifying enrollment. On October 1, 2013, Ohio launched *Ohio Benefits,* a simple, self-service website that makes it easier for Ohioans to sign up for the health care coverage that may be available to them. Through July 31, 2014, this system has processed over 825,000 applications. The success of this system comes from coordination from the state and local government entities.

Thank you again for the opportunity to explain Ohio's Children's Health insurance Program. Please let me know if you need any further information.

Sincerely,

[redacted]

John B. McCarthy
Director
Ohio Department of Medicaid

Cc: Ranking Member Henry A. Waxman, House Committee on Energy and Commerce
Chairman Ron Wyden, Senate Finance Committee
Ranking Member Orrin Hatch, Senate Finance Committee

Mary Fallin
Office of the Governor
State of Oklahoma

October 29, 2014

VIA ELECTRONIC TRANSMISSION

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
United States House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
104 Hart Office Building
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
United States House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Wyden and Upton, and Ranking Members Hatch and Waxman:

On behalf of the state of Oklahoma, I am pleased to submit this reply to the July 29 Congressional correspondence requesting our input on the continuation of Children's Health Insurance Program (CHIP) funding beyond Federal Fiscal Year (FFY) 2015.

Since 1997, Oklahoma's CHIP children have been enrolled in SoonerCare, the Oklahoma Medicaid program, which is currently a combination program. Members qualifying for SoonerCare under the CHIP program are under age 19 and have incomes between the maximum for standard Medicaid eligibility and 185 percent of Federal Poverty Level (FPL) guidelines. The majority of these CHIP children are enrolled in an integrated health care delivery system, SoonerCare Choice, which is a patient-centered medical home program. Since 2010, through Insure Oklahoma (a public-private premium assistance program) Oklahoma has been providing subsidized coverage through qualified small business employers to children from birth through age 18 who are not eligible for Medicaid and in families with incomes from 186 percent through 200 percent of FPL, as well as pregnancy-related benefits to some Medicaid-ineligible pregnant women.

Below are responses to the six questions outlined in your correspondence:

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?**

   In State Fiscal Year (SFY) 2014, Oklahoma had 155,718 unduplicated CHIP enrollees in its SoonerCare programs. Attached is additional information describing the demographic characteristics of this population.

2. **What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act (PPACA)? How has the implementation of PPACA impacted the way your state administers CHIP?**

   Oklahoma's real-time online enrollment system for SoonerCare, operational since September 2010, required significant and costly modification to its rules engine and single streamlined application to comply with the PPACA Modified Adjusted Gross Income (MAGI) standard. Because of the PPACA eligibility changes for income and household composition, extensive training modules were developed for both Medicaid agency staff as well as contracted call center staff in order to effectively assist Oklahoma families with children who were not eligible through the Federally Facilitated Marketplace (FFM). Because Oklahoma is an assessment state, the final eligibility determination is completed by the state's Medicaid agency. Overall, it is more complex and time consuming for Medicaid agency staff to accurately determine income under MAGI, adding an increased burden to Oklahoma.

   Oklahoma also made all necessary policy revisions and system changes to comply with the PPACA, including moving those children under 133 percent FPL from Title XXI to Title XIX.

3. **To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.**

   The majority of Oklahoma's SoonerCare CHIP children are enrolled in the Medicaid/CHIP combination program. As required by CMS, these children receive comprehensive medically necessary benefits, including non-emergency transportation, dental and vision care. These services are offered within the Medicaid cost sharing limitations.

   SoonerCare coverage for children, with CMS required benefits and wrap around services, is equal to Federally Facilitated Marketplace plans with a 90 percent actuarial value. Premiums for a comparable child-only plan for a 12-year-old in Oklahoma County, excluding dental and vision, currently range from $192 to $252 per month. There are premium variations across the state based on age, county of residence and scope of benefits.

4. **Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframes should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state will be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?**

   Yes, to allow time to resolve existing program or policy issues, such as the family glitch, and provide continuity of coverage to children, Oklahoma recommends the CHIP program be extended through FFY 2019. The family glitch refers to the situation in which employer-sponsored insurance for family coverage might prove too costly for low-income employees, even though affordable on an individual basis. This situation should be resolved during the extension period to ensure the health and financial security of our families and in a way that supports workers through enrollment in employer-sponsored health insurance. For state budgeting and planning purposes, Congress should take immediate action.

5. **Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?**

   Since FFY 2013, Oklahoma's annual allotments have not been sufficient to cover our CHIP expenditures. However, the state had enough unspent allotments from previous years to bridge the gap between our annual allotments and annual expenditures. For FFY 2014, Oklahoma's projected CHIP expenditures will

exceed the annual allotment. Once again, Oklahoma will rely on its unspent allotment for sufficient funding. With the continued pressure of program growth forced by the PPACA, Oklahoma expects there will be a need for increased allotments in the future.

Unspent allotments from each state might be more efficiently managed if Congress established and maintained a contingency fund for states that experience funding shortfalls.

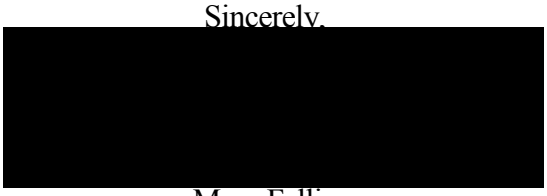
6. **Over the past number of years, states have worked to reduce the number of uninsured children and Medicaid and CHIP have been critical components in that effort. Do you believe federal policies could help states do an even better job in enrolling eligible children? What other policy changes, if any would help improve enrollment of eligible children, reduce the number of uninsured and improve health outcomes for children in your state?**

   I have stated health goals for Oklahoma that include improving population health outcomes, reducing the number of uninsured, increasing access to health services and improving the quality of care. To that end, I believe federal policies should support state managed programs to achieve these objectives. Oklahoma specifically supports the following programs and policies:

   - Provide flexibility to states for innovation and reward that innovation through incentive programs (for example, the CHIP performance bonus program);
   - Support quality measurement and improvement as a way to specifically address health outcomes through programs such as the CHIPRA pediatric quality measurement and improvement;
   - Reduce the burden on states for the PPACA enrollments by extending the use of CHIP allotments to cover previously Medicaid-eligible children; and,
   - Create program efficiencies by establishing and maintaining a contingency fund for states with annual CHIP expenditures exceeding that state's annual allotment.

In conclusion, Oklahoma believes adoption of these recommendations would have a positive impact on health outcomes for our youngest citizens by improving access to quality preventive and primary health care.

Sincerely,



Mary Fallin
Governor

SoonerCare CHIP SFY 2014

Race	Medicaid/CHIP	CHIP Standalone*	CHIP Total
American Indian	19,009	191	19,200
Asian or Pacific Islander	3,285	661	3,946
Black or African American	12,950	274	13,224
Caucasian	93,768	6,847	100,615
Declined to Answer	4,758	212	4,970
Multiple Race	13,667	96	13,763
Total	**147,437**	**8,281**	**155,718**
Hispanic Ethnicity	*30,673*	*5,642*	*36,315*

Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Gender	Medicaid/CHIP	CHIP Standalone*	CHIP Total
Female	72,799	7,930	80,729
Male	74,638	351	74,989
Total	**147,437**	**8,281**	**155,718**

Age	Medicaid/CHIP	CHIP Standalone*	CHIP Total
Infant (0)	3,563	5	3,568
1 - 5	29,996	149	30,145
6 - 12	64,699	282	64,981
13 - 18	49,179	511	49,690
19 & Over**	0	7,334	7,334
Total	**147,437**	**8,281**	**155,718**

Age as of end of SFY (6/30/2014).

**Only Soon-To-Be-Sooners members can be 19 & Over.

Federal Poverty Level	Medicaid/CHIP	CHIP Standalone*	CHIP Total
100% - 132%	66,424	5,995	72,419
133% - 149%	23,915	548	24,463
150% - 185%	57,098	1,738	58,836
Total	**147,437**	**8,281**	**155,718**

	Medicaid/CHIP	CHIP Standalone*	CHIP Total
Monthly Average Enrollment	76,870	3,201	80,071

*CHIP Standalone includes Soon-To-Be-Sooners (STBS) and Insure Oklahoma children. STBS provides limited coverage for pregnant women related to pregnancy-related health care services for the benefit of the baby.

Data valid as of 7/14/2014 and subject to change.

JOHN A. KITZHABER, MD
Governor

October 29, 2014

The Honorable Ron Wyden
Chairman
Committee on Finance
United State Senate
Washington, DC 20510

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
United State House of Representatives
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United State Senate
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
United State House of Representatives
Washington, DC 20515

Dear Chairmen Wyden and Upton, Senator Hatch, and Representative Waxman,

This letter is in response to correspondence to the state of Oregon from House Representatives Fred Upton and Henry A. Waxman, and Senators Ron Wyden and Orin G. Hatch regarding questions members of the bipartisan, bicameral committees asked about the Children's Health Insurance Program (CHIP) and considering whether and how the program should be extended, and what, if any, additional policy changes should be made.

We strongly encourage you to pass a long-term extension of the CHIP program as soon as possible. It has been and continues to be invaluable in ensuring access to affordable health insurance coverage for thousands of families in our state. Without an extension of the program and the funding, many children would be at risk of not being covered since premiums, co-pays and deductibles may be unaffordable for families. Also, the benefits covered under our CHIP program ensure that children have affordable access to a broader range of services including dental care, physical and speech therapy and vision services.

Oregon's responses to these questions are included here:

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?**

   There are 76,000 children enrolled in CHIP in Oregon as of June 15, 2014, about evenly split between males and females. We also cover over two thousand pregnant women who are Medicaid eligible except for their immigration status. Of children covered under the Oregon Health Plan (our Medicaid and CHIP program), CHIP children make up about 20%. The following tables show the income and demographics:

Age & Federal Poverty Level (FPL)	# enrolled as of June 15, 2014
< 1-18 years old, 100-200%	58,772
< 1-18 years old, 201-300%	17,726
Pregnant women	2,122
Total	**78,620**

Race	**% of CHIP population**
American Indian/Alaska Native	1.2%
Asian	3.4%
Black or African American	1.8%
Native Hawaiian/Other Pacific Islander	0.4%
White	57%
More than one race	0.5%
Unspecified Race/Unknown	35%
Ethnicity	**% of population**
Hispanic or Latino	16%

2. **What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?**

Oregon administers CHIP as a separate Medicaid "look alike" program. A couple changes made to the CHIP program since 2012 that were indirectly related to the ACA include:

- Transitioning the CHIP premium assistance commercial insurance option for children from 200-300% to direct coverage under for the Oregon Health Plan (the same as the CHIP program for children under 200% FPL), and increasing the income limits for children on OHP up to 300% FPL
- Per the ACA, some of the CHIP children (6-18 100%FPL – 133% FPL) were moved to Medicaid coverage (the "stair-step" children).

3. **To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or the cost sharing currently provided in your state that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.**

   Services not provided by Qualified Health Plans (QHPs) available at the Marketplace/Exchange and typically not available by employer sponsored insurance include:

   - Pediatric Dental – QHPs are not required to provide, so generally enrollees must purchase a stand-alone dental plan with additional cost shares and premiums.
   - Vision Services – Also available from QHPs, but with high deductibles, other cost shares, and limited benefits from QHPs. These services are not limited by our CHIP program.
   - Hearing exams, hearing aids.
   - Physical and speech therapy – QHPs have tighter limits on benefits than our CHIP program.
   - Non-Emergent Medical Transportation – This benefit is not available through QHPs or employer sponsored coverage and transportation is frequently a barrier to access for children in lower income households.
   - Enabling services – Sign language and translation/interpretation for individuals with limited English proficiency.

   In addition, the QHPs have cost sharing requirements for both premiums and co-pays/deductibles that our CHIP program does not. Even when the family does qualify for tax credits, the affordability of the premium may be challenging since the affordability criteria only looks at an employee's employer coverage, not what it costs to cover the family/dependents (the so-called "kid glitch").

4. **Do you recommend that CHIP funding be extended? If so, for how long and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?**

   Oregon recommends extending CHIP funding at least through 2019. During an extended funding period, many of the key issues regarding the affordability and adequacy of children's coverage could be addressed, and states and the federal government would have time and opportunity to determine what strategies will work best for the future.

   With CHIP funding currently scheduled to run out shortly after FY 2015, children now served by CHIP likely would be left to find coverage elsewhere – the Marketplace or employers if available. It is unlikely that low-income families would be able to afford the coverage on the exchanges given the "kid glitch". Also, low income families may not be able to afford to purchase some of the additional benefits that Oregon's current children can access such as dental care, physical and speech therapies, or to be able to get to the care needed if they were to have transportation barriers. In addition, given our experience, we agree with the Medicaid and CHIP Payment and Access Commission (MACPAC) that transitions to the Marketplace likely not would be smooth and that many children would likely fall in with MACPAC data that as many as half of our CHIP kids may lose coverage, which would erase much of our coverage gains for children that we've made over the past five years.

5. **In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?**

   Given that CHIP is capped and is allotted to states annually based on a methodology that relies on each state's recent CHIP spending, and that states have two years to spend each allotment, Oregon has not experienced any challenges in running low on allotment funds nor in having excessive leftover funds at the end of a fiscal year. Congress should consider keeping in place and extending the safety net provisions of CHIPRA, however, in order to protect states and optimize the use of funds. Under these provisions, if a state should run out of allotment, there are options of applying for funds from (1) the CHIPRA contingency fund established by the 2009 legislation; or (2) FY 2012 redistribution funds from states that did not exhaust their FY 2012 allotment after two years of availability.

6. **Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help States do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?**

   Oregon has seen a dramatic decline in the number of uninsured children by more than six (6) percentage points since implementing the State's HealthyKids programs in 2009 and has a rate of uninsured children 1.5 percent lower than the national average. This success was due in large part to (1) the expansion in the income eligibility criteria to 300 percent of FPL for families of children, (2) implementation of 12 month continuous eligibility for children, (3) the use of the option for Expedited Enrollment using SNAP and (4) the use of premium subsidies for children in families who chose to have their children covered in the family's individual or group insurance coverage or through the HealthyKids Connect program's private coverage.

   The state's implementation of the Coordinated Care model, and Patient-Centered Primary Care Homes as part of the Health Systems Transformation effort to better integrate and coordinate care and provide a full scope of coverage has already shown measurable improvements in health outcomes and key indicators of population health. Oregon, therefore, would encourage Congress to continue to allow states these and other available flexibilities to enhance both numbers of insured and health outcomes for children and their families.

Sincerely,

[redacted]

John A. Kitzhaber, M.D.
Governor

SK:gg

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR
HARRISBURG

THE GOVERNOR

October 31, 2014

Honorable Fred Upton
Chairman
Energy & Commerce Committee
2183 Rayburn House Office Bldg.
Washington, D.C. 20515

Honorable Ron Wyden
Chairman
Committee on Finance
221 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Honorable Henry Waxman
Ranking Member
Energy & Commerce Committee
2204 Rayburn House Office Bldg.
Washington, D.C. 20515

Honorable Orrin Hatch
Ranking Member
Committee on Finance
104 Hart Office Bldg.
Washington, D.C. 20510

Dear Chairmen Upton and Wyden, and Ranking Members Hatch and Waxman:

Thank you for contacting Pennsylvania regarding the future of the Children's Health Insurance Program (CHIP) and how it should be extended. As the leader of a state with more than 157,200 children enrolled in CHIP, there is no question that funding for CHIP should be extended on a federal level. We must allow CHIP to continue to successfully provide quality, affordable health care coverage to children. Moreover, addressing this issue promptly is critical for providing certainty to CHIP families and making sure that children can stay with their health care providers.

CHIP works for kids. Pennsylvania's CHIP program (PA-CHIP) has provided vital health care coverage to hundreds of thousands of children in Pennsylvania for over 20 years and is an example of how states can develop innovative solutions to meet the needs of their residents. PA-CHIP was enacted in 1992, and five years later, when the federal CHIP was created, PA-CHIP was acknowledged as a national model for the federal health care coverage program for children. PA-CHIP continues to be one of the benchmark benefit packages recognized in the federal CHIP law.

Pennsylvania has worked tirelessly to continue providing PA-CHIP coverage as an option for children and their families. However, as you know, the passage of the Affordable Care Act (ACA) serves as a challenge for PA-CHIP because it forces an efficiently functioning program to

conform to rigid federal standards. In addition to the ACA's overwhelming strain on the program's resources, the ACA has proved damaging to PA-CHIP's enrollment figures by requiring children in the 100%-133% Federal Poverty Level (FPL) range to be enrolled in Medicaid, rather than in CHIP.

Last year, Pennsylvania vehemently opposed a federal interpretation requiring an unnecessary transfer of children from PA-CHIP into Medicaid. I spoke personally with then-Secretary Kathleen Sebelius and said no child in Pennsylvania should be forced to change health care coverage and potentially lose access to his or her health care provider needlessly. Unfortunately, this is the scenario we now face because of the ACA. While the Obama Administration ultimately refused to grant Pennsylvania a permanent waiver from this ACA requirement in order to protect the child/health care provider relationship, we did successfully secure additional time to prepare for the transition and keep children with their providers for as long as possible.

When extending federal funding for CHIP, I also would suggest that the federal government use this extension as an opportunity to improve upon the federal program for the betterment of Pennsylvania's children and children nationwide. For example, Federal authorities should consider structuring flexibilities into the program for states, such as allowing states with separate CHIP programs the option to enroll children above 100% FPL in CHIP or Medicaid. Additionally, federal authorities should consider "at-cost" CHIP to be Minimum Essential Coverage (MEC), therefore avoiding unnecessary tax consequences for families.

With the health care needs of Pennsylvanian's children at stake, the extension of federal funding is critical to retain PA-CHIP as an option for families seeking health care coverage for their children. Thank you for the opportunity to share the importance of the extension of federal funding for CHIP and what it will mean for Pennsylvania's children and their families. With regard to your specific questions, please find the responses attached.

I urge you to extend CHIP's federal funding, and I look forward to working with you to improve this successful program.

Sincerely,

[redacted]

TOM CORBETT
Governor

Enclosure

Attachment A

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?**

Pennsylvania CHIP population characteristics. (September 2014)

Income Range

Income Range	$ 0	<$10,000	<$20,000	<$30,000	<$40,000	<$50,000	<$60,000	>$60,000	Total
Enrollees	1,596	1,443	5,360	28,613	41,773	35,759	20,709	22,642	**157,895**

Ethnicity

Ethnicity	Unspecified	Hispanic	Non-Hispanic	Total
Enrollees	21,200	15,523	121,172	**157,895**

Race

Race	Unspecified	African American	Caucasian	Asian	Hawaiian /Islander	Alaskan /Indian	Asian (Indian)	Other Race	More Than One Race	Total
Enrollees	11,338	21,737	102,744	5,337	81	138	854	13,927	1,739	**157,895**

Gender

Gender	Female	Male	Total
Enrollees	78,493	79,402	**157,895**

Cost Category

Cost Category	Free (133%-208%FPL)	Low Cost 1 (208%-262%)	Low Cost 2 (262%-288%FPL)	Low Cost 3 (288%-314%FPL)	At-Cost (314%FPL and above)	Total
Enrollees	120,637	23,395	5,895	4,512	3,456	**157,895**

2. **What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?**

As a result of the Affordable Care Act (ACA), Pennsylvania's CHIP (PA-CHIP) has faced tremendous operational and administrative challenges in order to comply with the requirements and expectations of the ACA, including but not limited to:

- Transitioned to the use of Modified Adjusted Gross Income (MAGI) to determine applicants' eligibility for PA-CHIP. The change to MAGI resulted in a complete reconfiguration of the methods by which PA-CHIP calculates applicants' income and determines applicants' household composition.
- Moved eligibility determinations out of the PA-CHIP Application Processing System and into a combined rules engine with the Medicaid program. PA-CHIP and the Medicaid program continue to work through discrepancies regarding eligibility, as the programs take different approaches to certain eligibility characteristics.
- Prepared for a transition of PA-CHIP enrollees ages 6-18 within 100%-133% FPL to the Medicaid program, consequently forcing enrollees to undergo an unnecessary transition of coverage and potential disruption in continuity of care.
- Implemented the "Single Streamlined Application" and renewal form. By changing the initial and renewal applications to remove requests for verifications prior to electronic verification sources being accessible, incomplete application and renewal forms accumulated to create a significant backlog. Each processing entity experienced significantly increased administrative workloads, and families experienced delays in processing and requests to produce paper verifications.
- Initiated coordination with the Federally Facilitated Marketplace (FFM) to transfer account information to and from the FFM. PA-CHIP faced significant challenges as the Federal Data Services Hub underwent inadequate testing and was not prepared to facilitate the transfer of the account information.
- Transitioned to Income Tax Rules, causing considerable confusion for a means tested program. Confusion as to the applicability of the rules to certain households'

composition continues, as federal regulators are still interpreting certain rules as to when or how income should be counted.

Currently, Pennsylvania administers a Title XXI CHIP through nine private insurance companies serving as contractors. (Title XXI of the Social Security Act allows states to operate a stand-alone CHIP program, separate and apart from a Title XIX Medicaid program.) The contractors provide healthcare benefits to the children, and are responsible for certain portions of the eligibility and enrollment process. Pennsylvania is the only state with this type of arrangement. In response to the ACA, along with the passage of the CHIP Reauthorization Act of 2009, PA-CHIP is performing a holistic assessment of the administration of the program to identify areas of possible administrative improvement. The review has thus far demonstrated the benefit of a Title XXI CHIP, and the corresponding use of contractors, as this administrative framework allows CHIP to operate very efficiently.

The ACA also impacted PA-CHIP's "Buy-In" program, which allows families with incomes greater than 300% FPL[1] to purchase the PA-CHIP benefit package at no cost to the state or federal government. Even though the Buy-In program maintains the same eligibility requirements and benefit package as the subsidized PA-CHIP, federal authorities have not yet concluded the Buy-In program constitutes Minimum Essential Coverage (MEC) for enrollees. Without this conclusion, enrollees in the Buy-In program may face penalties pursuant to the ACA's individual mandate if other coverage is not secured.

3. **To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.**

As a preliminary note, in a study performed by Deloitte Consulting, LLP (Deloitte) for Pennsylvania in August 2012, Deloitte analyzed the ten benchmark options for the exchange and concluded, among other things, that there was little variation in the benchmark options. Thus, for purposes of this response, the PA benchmark benefits and the majority of employer sponsored health plans in the state are assumed to be parallel, and our comments will focus on comparing PA-CHIP benefits and the PA benchmark benefits.

[1] Factoring in the ACA MAGI rules, 300% FPL is effectively 314% FPL.

Cost-Sharing

PA-CHIP has graduated levels of premiums and cost-sharing based on income level.[2] Under PA law, Free PA-CHIP covers children in families with an adjusted gross household income no greater than 200% of the FPL. There are no premiums and no co-payments collected for enrollees in this group. Low-cost PA-CHIP covers children in families with an adjusted gross household income greater than 200% but no greater than 300% of the FPL; these enrollees pay modest premiums.

Children in Low-cost PA-CHIP also are charged point-of-service co-payments for primary care visits ($5), specialists ($10), emergency room care ($25, waived if admitted), and prescriptions ($6 for generic and $9 for brand names). There are no co-payments for well-baby visits, well-child visits, immunizations, or emergency room care that results in an admission. Co-payments apply to physical health services but are no applicable to routine preventive and diagnostic dental services or vision services. Cost sharing for PA-CHIP, the combination of premiums and point of service co-payments, is capped by federal CHIP regulation (42 C.F.R. 457.560) at 5% of household income.[3]

In summary, PA-CHIP enrollees pay modest premiums, depending on income level, and have limited cost-sharing:

Income Federal Poverty Level (FPL)	Premium as a % of the Per Member Per Month (PMPM) Cost	Approximate Average Premium Cost to Enrollee Per Month as of September 5, 2014	Total Premium Plus Cost-Sharing Per Year as % of Household Income
<201% FPL	0%	$0	0%
201% FPL – 250% FPL	25%	$50.25	5%
251% FPL – 275% FPL	35%	$70.35	5%
276% FPL – 300% FPL	40%	$80.40	5%

[2] As noted above, PA-CHIP also has a full-cost component for those above 300% FPL, which is not subsidized by either federal or state dollars. In keeping with the focus of the Congressional inquiry, this cost-sharing discussion addresses only the subsidized components.

[3] 42 C.F.R. §457.560(a): "A State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of a family's total income for the length of a child's eligibility period in the State."

By comparison, premiums for the second lowest cost silver QHP in Pennsylvania for 2014 plans ranged from $84.46 to $149.13.[4] Moreover, with the addition of cost-sharing, premiums plus cost-sharing under the ACA may be substantially more than 5% of household income, even with premium tax credits and cost-sharing reductions.[5] Focusing on the cost-sharing differential only, a study by Wakely Consulting Group in July 2014[6] concluded that the cost sharing (deductible, copays, and/or coinsurance) for a child on a silver plan, with cost sharing reduction subsidies, would be considerably more than the cost sharing for PA CHIP coverage:

Income Level Coverage	160% FPL		210% FPL	
	PA-CHIP	QHP	PA-CHIP	QHP
Actuarial Value	100.0%	86%-88%	97.2%	72%-74%
Enrollee Average Percent of Allowed Claims	0.0%	12%-14%	2.8%	26%-28%
Average Annual Cost Sharing	$0	$411-$480	$98	$891-$960
Maximum Out of Pocket	$0	$500-$2,250	$1,419	$3,000-$5,200

This cost-sharing structure of PA-CHIP compares very favorably to QHP coverage available through the exchange. In many instances, cost-sharing for PA-CHIP enrollees will be equal to or less than a family would experience with enrollment in a QHP.

Benefits

PA-CHIP provides identical, comprehensive benefits to individuals enrolled in all levels of the program. Basic services include:

- Preventive care, including physician, nurse practitioner and physician assistant services;
- Specialist care, including physician, nurse practitioner and physician assistant services;
- Autism services, not to exceed $36,000 annual benefit cap (specified by Act 62 of 2008);
- Diagnosis and treatment of illness or injury;
- Laboratory/pathology testing;
- X-rays;

[4] http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm.
[5] *See, e.g.*, www.communitycatalyst.org/doc-store/.../affordability_in_aca.pdf; http://www.kaiserhealthnews.org/features/insuring-your-health/2013/070913-michelle-andrews-on-cost-sharing-subsidies.aspx.
[6] "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans", Wakely Consulting Group, July 2014 ("Wakely Study") available at http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf.

- Injections and medications;
- Emergency care, including emergency transportation;
- Prescription drugs;
- Emergency, preventive and routine dental care, and medically necessary orthodontia;[7]
- Emergency, preventive and routine vision care;
- Emergency, preventive and routine hearing care; and
- Inpatient hospital care (90 days including mental health).

Additional medically necessary and therapeutic services include mental health services, inpatient and outpatient treatment of substance abuse, rehabilitative therapies, medical therapies, home health care, hospice care, durable medical equipment, and maternity care.

Significantly, the Wakely Study distinguished child-specific benefits – those that are other than the core benefits typically included in a major medical insurance policy – and found that PA-CHIP covers 79% of those services, while QHPs cover only 50%. Child-specific benefits focus on dental, including orthodontics; vision; audiology; habilitation; and therapy coverages.[8]

PA-CHIP, like QHP coverage, includes some limitations on benefits. However, it is difficult to compare those limitations with the QHP coverage of those benefits for two reasons. First, QHPs may also impose limits, but data is not readily available to identify the frequency or level of those limitations, and the limits may vary by product and plan. Second, if a child is approaching those limits on PA-CHIP, it is likely that the child will be eligible for Medicaid coverage through a special PA Medical Assistance program for children with special health care needs or chronic conditions (for which income is not considered when determining eligibility).

4. **Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?**

Federal funding for CHIP should absolutely be extended promptly. PA-CHIP has provided health care coverage to hundreds of thousands of children in Pennsylvania for over 20 years and

[7] As a result of the CHIP Reauthorization Act of 2009 (CHIPRA), medically necessary orthodontia was added to the dental benefits package. The orthodontia benefit is capped at a lifetime maximum of $5,200. The yearly dental benefit limit is $1,500.

[8] *See* Wakely Study at Table 16, pages 26-27.

is an example of how states can develop innovative solutions to meet the needs of their residents. Pennsylvania has worked tirelessly to continue providing PA-CHIP coverage as an option for children and their families. With the health care needs of Pennsylvanian's children at stake, it is critical that federal funding be extended to allow PA-CHIP as an option for families seeking coverage for their children.

Pennsylvania strongly recommends that federal funding be extended to align with Congress's authorization of the program, i.e. through fiscal year 2019. As current federal funding of CHIP is set to expire on October 1, 2015, Congress should begin the reauthorization process immediately. States, as partners in the CHIP program, need the timely assurance of funding as they prepare their budgets. But perhaps more critically, Congress should urgently address the continued appropriation of federal funding for CHIP to provide certainty for families who rely on CHIP coverage for their children.

In the absence of CHIP, families would have fewer options for accessing health care and more than 157,200 Pennsylvania children would need to find replacement coverage, which could take time, be more expensive, and potentially jeopardize the children's access to health care services. This would be devastating to Pennsylvania families.

5. **In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?**

The states' allotments are based on complex methodologies specified in Section 2104(m) of the Social Security Act. Each state's federal fiscal year (FFY) allotment is adjusted based on several factors, including per capita health care growth and the child population growth.

For FFY13, ACA mandated a "rebasing" process to determine the allotment. This methodology bases the allotment on the states' payments (i.e., based on enrollment) rather than the allotments for FFY12. For FFY14, the methodology reverted to using the prior year allotments as a base. For FFY15, there will be two allotments: one for each six months of the FFY.

Pennsylvania has been fortunate since the passage of CHIPRA to have adequate federal funds to meet the increased demand for the CHIP services. We saw our CHIP enrollment increase from 183,000 to nearly 198,000 between early 2009 and mid-2010 before enrollment again levelled off and began a slow decline through 2012. The decline has continued due to the ACA requirement that children in the 100%-133% FPL range be enrolled in Medicaid, rather than CHIP.

The federal matching rate is set to increase by 23 percentage points beginning in FFY15. This will lead to a quicker exhaustion of federal CHIP dollars. Simultaneously, as Pennsylvania has

experienced leaner enrollment figures – partially attributable to the unnecessary transfer of children to Medicaid – the formula works against Pennsylvania since the program's lower enrollment numbers will be used for calculating future allotments (rebasing). Thus, just as the matching rate is set to increase by 23 percentage points – resulting in a quicker exhaustion of federal CHIP funds – Pennsylvania will receive a smaller allotment of federal funds to support its CHIP program. Many states will be in a similar predicament.

In sum, it may be wise to take unspent funding from past years and make it available to states, such as Pennsylvania, that have decreased CHIP enrollment due to Medicaid expansion, so that their programs will not be doubly jeopardized when the significantly increased federal match funds are distributed in accord with the rebased allotments.

6. **Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?**

When contemplating federal policies to reduce the number of uninsured children, Pennsylvania suggests a shift of focus away from only looking at the number of enrollees and move towards structuring programs that empower families to get engaged in improving their health and becoming more well-informed consumers of their health care. Focusing solely on the fluctuations in enrollment numbers distracts advocates, legislators, auditors, and others away from the overall goal of improving the health of children by ensuring there are a range of coverage options to allow a child to be covered, regardless of changing life circumstances. Under Governor Corbett's leadership, the health care coverage rate for children in Pennsylvania is close to 95%. While this is extremely high, Governor Corbett believes we can still do more and has pushed to continuously work toward getting all kids covered while also seeking to strategically improve Pennsylvania's overall health insurance system. Any policy changes contemplated by the federal government should align with Governor Corbett's *Healthy Pennsylvania* priorities: providing affordability, improving access, and ensuring quality.

Access to health care coverage must be affordable for consumers. To accomplish this, more incentives should be built into government programs to allow states to help individuals transition from fully subsidized coverage to self-sufficiency, such as additional premium assistance for employer-sponsored insurance. Policymakers should shift away from eliminating premiums, and rather toward giving states the flexibility to develop premium structures that are affordable for consumers and begin to build into these programs various levels of health care consumer engagement and a stronger focus on healthy behaviors. CHIP premiums are designed on a sliding scale based upon a family's ability to pay. As income increases, the cost-sharing rises closer to what is experienced in commercial health insurance coverage. The flexibility to stagger

cost-sharing would allow the program time to engage consumers and begin educating enrollees on the benefits of having a personal stake in improving their health. Establishing greater flexibility could lead to the development of healthy behavior incentive programs that reward good health care choices and improved health, therefore, allowing CHIP enrollees to receive some of the newest innovations in health care coverage that are found in the commercial health insurance market.

Access to health care coverage must also be available for consumers. Policymakers should focus on how to attract and retain highly qualified medical professionals as providers to facilitate better access to the health care system. As enrollment numbers increase, so potentially do the wait times to see a practitioner. When individuals desire to be in the medical profession, we should provide incentives to fill the gaps as far as medical specialties – including general practitioners – and geographic locations. As part of *Healthy Pennsylvania*, Governor Corbett continues to support loan forgiveness programs to incentivize primary health care providers to practice in rural and underserved areas of the Commonwealth.

Policymakers should seize the opportunity presented by the federal extension of CHIP to improve upon the program's strengths, and to allow CHIP to serve as an integral bridge to independence for CHIP children and their families.